EXHIBIT 45

UNITED STATES DISTRICT

FOR THE DISTRICT OF MASSACHUSETTS

IN RE: PHARMACEUTICAL	)	MDL NO. 1456
INDUSTRY AVERAGE WHOLESALE	)	CIVIL ACTION
PRICE LITIGATION	)	01-CV-12257-PBS
THIS DOCUMENT RELATES TO	)	
U.S. ex rel. Ven-a-Care of	)	
of the Florida Keys, Inc.	)	
v.	)	No.06-CV-11337-PBS
ABBOTT LABORATORIES, INC.,	)	

(cross captions appear on following pages)

Deposition of HARRY LEO SULLIVAN

Volume I

Nashville, Tennessee

Tuesday, March 12, 2008

9:05 a.m.

Page 58

you're talking specifically about a MAC process?
Q. The data that would tell me essentially what was paid and how it was determined what would be paid.
A. Nothing in the computer will tell you how the price was determined. But there should be records of -- because that was all manually input at that time. And I, I'm the one that did it.
I would literally go -- I could log into the mainframe and change prices. It would put a date on there. It would even print an audit trail, of any changes, because, you know, I had a user name and anything I did in that computer there was an audit trail printed out to -- and I guess, I would assume, some taped copy as well.
And you needed that because, and you needed historical information in the claims processing system because Medicaid claims typically can be submitted all the way back 365 days a year.

Page 59

But you may have cases like SSI determination that may take two or three years for the patient to be determined SSI eligible, automatically Medicaid eligible, and they can submit back from the beginning of that determination period all their pharmacy claims.
So you have to be able to process those claims and pay the price that was appropriate at that time of dispensing.
There should be records of that.
Q. We'll talk about the MAC program a little bit later, but if you wanted to change a price for a particular drug, you had the ability to go into the computer and change the price?
A. Yes. I did. I don't -- I wouldn't say that was true in every state.
Q. Okay. What authorities, if any, would you have to go through in order to change a price for a particular drug?
A. That was my responsibility. I, I, I would do it as part of my job, as part of making sure that -- two things occurred, particularly

Page 60

with multi-source drugs. One, is that we didn't pay too much. And, two, is that we paid enough to insure an incentive for pharmacists to take the extra step to, if necessary, call a physician and get the prescription changed to a multi-source drug.
Q. And when you talk about an incentive you're talking about a financial incentive?
A. Yes.
Q. And what kind of financial incentive would you provide?
A. What, what I tried to make sure I did during this time, this -- I would say from '89 to '94, was, was make sure that there, there was profit to be made for a pharmacist for dispensing generic drugs. It -- these, these folks are pretty savvy.
If I'm paying based on what I have submitted to HFCA at the time or CMS today on a state plan that says I will pay AWP minus 10 plus $4 or 3.91 or $4, whatever, for a brand name, and I'm setting MAC prices on the corresponding

Page 61

generic that pay the pharmacist his or her net cost, it's not going to take them very long to figure out which drug to process.
When they can buy the drug at, you know, AWP minus 18, 20, 22, versus selling it at cost plus a dispensing fee, they're going, they're going to figure that out. And I'm shooting myself in the foot from a budget standpoint, from a, trying to be a responsible manager for the state's taxpayers.
So you, you want to -- you want there to be some measure of profit, some incentive over and above a dispensing fee, to incentivize pharmacists to use the generic.
Q. We'll talk about some other communications that you have had with some other state Medicaid programs, but was that issue creating a financial incentive to promote the use of multiple-source drugs something that you discussed with other state pharmacy administrators?
A. Maybe at national meetings where there

might be some, some discussion on, you know, brand versus generic, or to use a MAC or not to use a MAC.

You also have issues in different states of do they allow dispenses written? Do they have a two-line prescription form? Or what are their particular guidelines for physicians and pharmacists when it comes to being able to substitute a generic? So, but I don't remember saying, you know, I'm paying 2 cents apiece for generic penicillin, what do you pay? What -- I don't, I don't think anybody ever did that.

Q. From your experience, do you think it was well accepted amongst the Medicaid pharmacy administrative community that you would want to pay some profit on multiple-source drugs to incentivize their use?

MS. DAMOULAKIS: Objection.

A. It's just so fundamental, I don't remember discussing that with anybody. I think it's just -- it's something you -- you know, I mean it's just -- makes good sense. I don't, I

don't remember any specific discussions with anybody on, you really need to make it profitable so that they will have an incentive to use it.

BY MR. TORBORG:

Q. In your view it's just one of those fundamental tenets of how you operate a state Medicaid pharmacy program.

A. One of my bosses long ago told me that the color of health care is green, and that's true.

Q. In your time as the director of pharmacy services, did you have communications with the federal government concerning drug payments?

A. I don't know in what context you would -- I mean can you -- is there another way you can ask that question?

Q. I'll try.

In determining how much the state should be paying for drugs, both as an ingredient cost component and as a dispensing cost component, did you have discussions with the --

any representatives from CMS then known as HFCA.

A. I couldn't name any individual in HFCA or CMS, and I don't remember -- and I couldn't tell you the exact time. I would say in the, in the early Nineties HFCA putting directives out to the state, and it was, it was as if they're suggesting that, you know, we're going to be looking -- kind of giving you a heads-up, the way they would do with, with policy. That, you know, we're aware that a lot of states are, are paying AWP minus 5 or whatever. And we really think that y'all need to get to maybe 10 percent. I don't know where -- you know, if OIG or somebody gave them some number. They wanted everybody to get to 10. Or some convoluted calculation of WAC or acquisition costs or however you could get there that would demonstrate to HFCA that you're doing about AWP minus 10.

Tennessee was -- and this may -- there may be various constraints on other states. For example, some state may -- reimbursement may be subject to legislation within the state. May

have to be legislated. It may be up to the Medicaid director or the pharmacy director, it may be tied to a cost-to-dispense study from a state university, college of pharmacy, or something like that. So it -- I'm sure it varied wide, widely from state to state on their flexibility to comply with, with such a -- and it wasn't a mandate at that time. But it was -- you could clearly tell that HFCA was wanting something done with reimbursement for pharmacy services that, that I guess saved money or more closely approximated what people were really paying for drugs.

Q. You made a comment or some comments about some of the -- tell me if I'm paraphrasing you wrong here -- but there might be some roadblocks that would come between a state pharmacy director and wanted to comply with what HFCA wanted to do. Is that fair to say?

A. Well, no, ultimately, in Tennessee, for example, at that time, and really pretty much still today, two-thirds of the bill's paid by the

Page 106

compendia were matching the actual market prices as they lowered on generic drugs?
A. For multi-source drugs?
Q. Yes.
A. I had no knowledge, and I didn't care because if it was up to me, I think, as my job, to find out what the net cost was to the pharmacist.
Two things, availability, statewide, in Tennessee, of the generic, and, secondly, what are they paying? I have to know that in order to get back to what we were talking about earlier, providing the proper incentive to dispense generic for the pharmacist to do whatever intervention was necessary with either the patient or the physician, or both, to get the generic substitution accomplished.
Q. Now where would you get the information that you would use in the MAC program regarding what pharmacists were -- pharmacies were actually paying for drugs?
A. My, my system was, was not very

Page 107

sophisticated or very scientific, but nonetheless believe it to have been very effective.
What I did was, I knew I had a contact within the largest generic distributor in our area, and one of the most -- one of the more popular. Again during this time that I, that I was setting MAC prices, rather than MCOs or PBMs, the, the best deal on generic weren't coming from, from big wholesalers. They were coming from generic distributors.
So I had contacts within this one particular company who would tell me, who would first of all keep me apprized any time they, they were able to distribute new generic drugs, also give me information if, if there was some problem with an existing generic drug's availability, and also tell me and give -- send me catalogs that they sent to the pharmacists and then tell me additionally what am I looking at for this drug X, Y, Z, what does a hundred of them cost a pharmacy? I didn't look at Red Book or Blue Book or First Data; I called the people that sell it.

Page 108

Then I took that information, and never going to take at one source completely at face value, then I would call three or four -- I used independent pharmacists in different parts of the state, and I called. And I said, I understand, and I wouldn't mention that particular distributor. They never knew where I got my numbers. The pharmacists never knew where I got my numbers. But I would say, I'm thinking, I believe that you can get this new generic, or whatever it is, for five dollars a hundred, and I'm going to set the MAC at 7.50 a hundred. Does that give you any heartburn? And that's the way I did business.
These, I trusted these people, obviously. But there are three different sources there who are on the front lines in a pharmacy who are running a business, who they have a personal stake in. That's why I went to independents. And then the distributor, who is selling. And who over the course of that interaction I never found them to be anything but

Page 109

honest.
So -- and you can, you can quickly tell if you have got something set too low, the phone will ring.
So that -- and then I just -- I built in a little, 30 percent or whatever, profit to a generic MAC. But I would immediately MAC -- AWP was irrelevant. For generic drugs.
Q. And did you have a practice for doing, for doing this process for all generic drugs?
A. Yes.
Q. And you did this all by yourself.
A. Yes.
Q. One person?
A. Yes.
Q. And you had other duties as well, --
A. Yes.
Q. -- correct?
A. Yes.
Q. And tell me a little bit about --
A. Of course, you know, I, when I went to work there in '89 we already had a MAC program.

Page 110

Tennessee was I still believe the first state to have a MAC, long before the Feds put in the federal limit program. And so it wasn't like I had to suddenly do a thousand drug MACs and do all those -- gather all that data and do those calculations. It's as they come out. You stay on top of it.

Q. Um-hum.

A. Okay? There aren't, you know, a hundred different generics coming out each month or something.

Q. And did you have a system that you used to, for lack of a better word, crosswalk various generic products from different manufacturers to the same number --

A. Yes.

Q. -- or something like that?

A. Yes.

Q. How did you do that?

A. There were two, during my career there were two, (coughs) excuse me, different time frames where prior to OBRA -- the full

Page 111

implementation of OBRA '90 from a claims processing standpoint for electronic claims processing. We were still accepting paper back in '89-90. And at that point in time -- and again we had a very restricted formulary. We had a five-digit code for every drug, be it brand name or generic. There was -- you know, if there were 15 different manufacturers of penicillin, 250 milligrams, they all had the same code. I didn't care which manufacturer the pharmacy used, per se. They bill me penicillin 250 with one five-digit code. And I maintained those codes and maintained them in the fiscal agent's claims processing system. I did all the updates to that.

Then along came OBRA '90, on top of having the, the mandate of going to electronic claims processing, you're suddenly cognizant of the fact that you have to collect for invoicing purposes NDC level data to get the rebates you're due through the process.

So what we did then was switch -- I had

Page 112

to, I had to go through and literally this was a hands-on thing, too, crosswalk, build crosswalks between -- well, let me, let me go back. I don't want to make this too convoluted.

We would get updates from I believe Blue Book at that time, which later became First DataBank, I think, through the claims processing system, for all drugs, pricing information, AWPs. For brand and generic. But we MACed all the generic. So that was overridden into a different column for the claims processing system that recognized for this drug there is a MAC, and that's how it pays, all right?

So all the NDCs went into those codes, those five-digit codes. We had to totally swap that in the system when you had to go to online claims processing and develop invoices for the rebates.

So had to take every one of those five-digit, digit codes and made sure they were all to the right NDC numbers, just totally flip-flopped the whole system.

Page 113

Q. Why did Tennessee go through all this trouble?

A. Well, it was just you had -- I, I think part of it was resistance to move to computers. At that time, for example, when we first went to online claims processing, we had I want to say 3,000 pharmacies in the state that participated in Medicaid, and FirstHealth, we made FirstHealth buy like 250 laptops. And we just -- we delivered to drugstores that didn't even have computers. They were processing just on typewriter --

Q. Um-hum.

A. -- and keeping old records.

But there was, there was some resistance to move from, from a paper system even in the -- in the -- those that had computers didn't have the capability to be online. They had computers that would, once a month, print out on a dot matrix printer on triplicate forms that we sent them all the Medicaid claims and mailed them in to us, and there would be then data

Page 114

entered into our system, and then paid eventually.
Just resistance to change, I guess.
Q. Did you -- did you have any involvement when the MAC program was first started in Tennessee?
A. It preceded me.
Q. And do you have any insight as to the amount of labor involved to get the process underway?
A. It would have been significant, but not anything like you started from square one today, because, number one, there weren't that many drugs. Weren't that many multi-source drugs. And we had a very restrictive formulary. So even if there was -- for a lot of drugs, even if there was a generic alternative, even the generic wasn't covered.
Q. When you were the director of pharmacy services, Tennessee Medicaid, from '89 through 2004, save the, the nine months, did you believe that you had no choice but to use the AWPs and

Page 115

the compendia to set payment rates for generic drugs?
MR. DRAYCOTT: Objection.
A. Had no choice. As -- well --
BY MR. TORBORG:
Q. When you say you had no choice, what do you mean?
A. That was your question, I think, you had --
Q. Did you believe that there was no other practical alternative but to use what was in the compendia --
MR. DRAYCOTT: Objection.
BY MR. TORBORG:
Q. -- to reimburse generic drugs?
A. It was, it was the most expedient is all I would say. And it was going when I got there, and I would say an industry standard that we, that we -- a wheel we couldn't reinvent.
Q. But you used a MAC program to reimburse generic drugs; is that right?
A. Yeah. Now I thought you were talking

Page 116

about brand name in your original question.
I keep the two totally separate. I have never reimbursed anybody for generic based on AWP.
Q. So would it be fair to say that you believed you had another choice to set reimbursement rates for generic drugs?
A. Oh, yes.
Q. Apart from the compendia.
A. Yes. Yes. I'm sorry.
Q. You mentioned federal upper limits in one of your previous questions. I think we both know what that's, what that's all about.
Did you become aware at any point during your work with Tennessee that CMS apparently deliberately did not establish federal upper limits for intravenous and injectable drug products?
MR. DRAYCOTT: Objection.
A. I wouldn't say that I ever knew that they intentionally didn't do that, but I -- you know, the -- I don't remember -- I don't remember

Page 117

injectables being part of the FUL, but it could have been. I, I just don't remember that.
Again, that's another thing that, in Tennessee, and I'm sure this will vary again from state to state, in Tennessee we chose, for example, in a physician's office, under certain settings, or home health is probably a better example, certainly certain drugs and other things, all of them, we wanted to run through the pharmacy program. For several reasons. The reimbursement for drugs on like a HFCA 1500 or whatever the -- would have happened from a home health agency to a home health division within TennCare to process, those folks had no clue that if -- what the difference between what was billed and what should be paid should be. So typically a hundred percent of bills was paid. So we didn't want, didn't want that situation. We wanted it to certainly be fair, but wanted most of those things to come through the pharmacy program to control costs.
So in the instance of IV solutions or

Page 150

concerns on whether or not the payment for these kind of therapies was, was adequate?
A. Well, my opinion, particularly in the, in the home health arena, was -- and during this specific time period, the growth in Tennessee was such of those type of providers that it wouldn't -- that wouldn't -- not lead you to believe that the reimbursement for Medicaid was inadequate.
When people are hollering and screaming or you have trouble getting providers to take care of your patients is when that was more likely a concern.
Q. Well, do you know when the home infusion business really started taking off?
A. Well, it certainly took off in the early Nineties. And I can't remember -- and Tennessee was a little bit different because we very purposely avoided expansion of home community based services under the Medicaid program because the vast majority of the patients who would receive those services were dual eligibles, which meant they had Medicaid and

Page 151

Medicare. And Medicare home health was, was truly exploding. We had hundreds of providers in Tennessee of home health services. I dare say there's, you know, maybe 20 now. Because there was, there was indeed a bonanza on the Medicare side in Tennessee. Other states didn't face it quite as -- if they had chosen to expand or had very aggressive home community-based services through Medicaid, might have had a little bit different policy issues. We purely shifted to Medicare, cost shifted to Medicare, with the duals. And so it wasn't maybe not as, as intense on a Medicaid issue in Tennessee as it might be elsewhere is what I'm saying.
Q. The page starting with -- at 425 and then going over to 426, there is a discussion of what some states are doing in the home IV reimbursement area, Minnesota indicates compounding or a dispensing fee of $8 for IV drugs, and then Washington indicates that they're paying a compounding amount, Ohio as well.
Do you have an understanding of what

Page 152

they're talking about when they talk about a compounding fee?
A. Yes.
Q. And what, what is that?
A. Well, certain, be it -- I mean you can compound IV drugs if you have the right equipment and filters and hoods to keep it, make it a sterile product.
And you can compound drugs for inhalation. If you have, again, the right equipment, similar to what would be in a hospital, to, to handle sterile products.
And you take the raw ingredient and mimic whatever, generally, the brand name or the innovator product was.
Q. And do you know in Tennessee, either before TennCare or after TennCare was paying a compounding fee for IV? Do you know if that was something that was being paid?
A. Ah, no. But there's, there's ways to pay it without, without having a separate -- you know, I noticed on here that one form is for

Page 153

payment, one form is for reimbursement of supplies, one form is for -- you know, they're, they're making a variety to submit multiple forms. And I wouldn't -- I can't tell you a specific product or specific time period, but one of my strategies was in issues like this, where compounding was involved, I didn't want to go down the road, at least in the early Nineties, of getting into paying for compounded prescriptions, because that can -- that could range from a sterile product all the way down to an ointment, okay?
And, and our claims reimbursement system hadn't evolved to the current NCPDP sophistication of today. So it was very hard to put in a, a set compounding fee for what, what products?
One may take a minute to make, one may take an hour and a half.
So getting back to, to the MAC issue, some, sometimes for certain products in this arena, you would take that into account for the

Page 154

MAC.
For example, I might say, I'm not paying for the tape that you use to hold the IV needle into place. I'm not paying for the IV needle or the tube set. I'm not going to -- I don't want bills for that. I know you've got to do it to administer this drug. So we're going to add on the cost of this drug X, because I know this, this and this always goes with it, and I know there is a fixed cost for that, but I don't want five bills. I want 10 different places. Bill me for the drug. And I'll make sure that the -- whatever the MAC is incorporates all your other costs. And you have to talk with providers and know what that is. I mean, you know.
Q. So, in short, you would use the payment for the drug itself to cross-subsidize other things that might need to be paid to fairly --
A. And that would include compounding.
Q. And it may include nursing services that were not included, things of that nature?
A. (Nodding yes.)

Page 155

Q. Did anyone in the federal government ever tell you that you were not allowed to do that?
A. No.
Q. And if they had told you that, what would you have said?
A. That I wasn't allowed to pay for compounding or --
Q. That you weren't allowed to use the payment for the drug to cross-subsidize those other services or supplies.
A. If they had told me I couldn't do it, what would I do?
Q. Yes.
A. I would have had to have found another way to, to handle the billing.
Q. But they never told you that.
A. No.
Q. Do you know if other states were doing -- were adopting similar type strategies to run the programs?
A. No, I don't -- I mean it may be

Page 156

addressed in this letter. I don't know. It seems to talk about different states, but I'm sure there were varying levels of complexity in the billing process, and what was and wasn't billable and what was and wasn't included, but I don't know it and I didn't discuss it with folks.
Q. Have you heard the term cross-subsidy or cross-subsidization in the context of pharmacy reimbursement?
A. No, not -- no, I haven't.
Q. I'm going to show you another, another -- going to mark that as another exhibit.
MR. TORBORG: I think this is 578.
(Exhibit Abbott 578 marked.)
BY MR. TORBORG:
Q. For the record, what we have marked as Exhibit 578 bears the Bates numbers HHC 002-0400 through 407. It's another Medicaid pharmacy bulletin. This one dated January-February of 1988.
Mr. Sullivan, if I could ask you to go to Bates page ending in 402. In particular the

Page 157

discussion on the first full paragraph about Montana Medicaid. Do you see that?
A. Yes.
Q. Where it says, Similarly, Montana Medicaid compensates for the additional time and expense of dispensing compounded drugs by allowing the provider's usual and customary charge up to 2.5 times the cost of ingredients, paren, reimbursement for other outpatient drugs is a lower of AWP minus 10 percent, or the cost of the drug, end paren. Do you see that?
A. Yes.
Q. Is that the, the type of thing that Tennessee was doing?
A. It's a different approach to -- yeah. Make -- paying the provider for the, for the compounding without -- and setting a limit on what I will pay up to two and a half percent. It's just a different, different twist.
Q. Does it -- does this refresh your recollection about any other types of approaches like this that other states were using?

Page 166

exhibit.
(Exhibit Abbott 579 marked.)
BY MR. TORBORG:
Q. For the record what we have marked as Abbott Exhibit 579, bears the Bates numbers HHC 902-0657 through 65, excluding 61 and 62.
A. Hmm.
Q. Mr. Sullivan, I take it from your reaction to the document that you're familiar with at least some of the material contained within this?
A. Well, it's just interesting that you threw this out right after you asked the previous question. That's why, what made me giggle.
Q. If you would take a look at that and let me know if you're familiar with any of these documents and then I'll ask you some questions about it.
A. Okay.
Q. I'll be starting with 660 and then working my way sort of chronologically through the document.

Page 167

A. Okay.
Yeah.
Yeah, yeah, this came from NACDS.
I don't remember seeing this. I remember the discussion. I don't remember seeing this document.
Q. Which document is that?
A. The second page.
Q. The second page?
A. This was... hmm. So yeah. Yeah, this was another good idea that didn't work.
Q. Okay. Let me try to paraphrase what I think was, what's reflected in these documents, at least in part.
A. Okay.
Q. And you can tell me if I'm wrong just to kind of speed things up.
It appears as though sometime in 1991, December 1991, Tennessee -- your, your Medicaid (c) issued a bulletin that indicated that usual and customary charges should be the amount that is no greater than the lowest contract price to

Page 168

another customer.
A. That's right.
Q. And an organization called the national association of trained drug stores took exception to that.
A. To say the least.
Q. And indicated that was not consistent with the moratorium that had been put on changes to drug reimbursement in the OBRA '90.
A. OBRA '90, yes.
Q. And then there was some communication from the regional office of HFCA to your office, or Tennessee Medicaid.
A. (Nodding yes.)
Q. And then there is some correspondence that you may not have been aware of from the regional office to HFCA headquarters.
A. Um-hum.
Q. Is that a fair recitation of what these reflect?
A. Yes.
Q. And do you recall this, this issue?

Page 169

A. Yes.
Q. Okay. Tell me what you recall about this.
A. Um, we -- I thought, that the OBRA '90 was irrelevant, but because North Carolina had a most favored nation policy, and vigorously enforced it, when I put out this bulletin saying we're going to do the same thing, NACDS was, was real upset and took the approach with HFCA that this was something new, and it had -- and it violated the OBRA '90 thing on some moratorium on changes to pharmacy reimbursement.
The -- we had some ongoing negotiations with NACDS, started out very contentious at first and wound up pretty, pretty amiable.
The, the best argument they had was our reimbursement rate with Tennessee Medicaid was pretty low, was lower than most states, and that it approached the ground level anyway, of what they were getting that moment in time, from other third-party payers. So the juice of enforcement really wasn't worth the squeeze of the benefit.

Page 170

So we backed off and never did implement the policy is really, really the way it played out.
Q. Do you know why it was -- were you involved in --
A. And then, and then when's, sometime after that, I wouldn't absolutely swear to it, but I believe then we -- that usual and customary piece, either in a bulletin, I don't want -- or maybe the state plan, something was thrown in there to the cash-paying public or to the general public, or something, some clarification of that.
Q. Were you involved in this issue yourself?
A. Yes.
Q. So even though the letter comes from Manny Martens, --
A. Yeah, I wrote it.
Q. You're the one that wrote it?
A. Um-hum.
Q. And what you were trying to do was to -- is it fair to say that what you were trying to do was to make the usual and customary charge for

Page 171

a pharmacy claim submitted by a provider --
A. Well, it was just --
Q. -- mean something real?
A. It was -- no. It was, it was simpler than that.
It was the imposition of something similar to North Carolina, which is a most favored nation clause.
If you're willing to accept AWP minus 20 plus a dollar from anybody, the State of Tennessee should get that same deal. That was what I was after. It didn't work.
Q. Did you believe comparisons to what other third-party payers were paying for drugs is a useful metric regarding what Medicaid programs ought to pay for drugs?
MR. DRAYCOTT: Objection.
A. No.
BY MR. TORBORG:
Q. And why is that?
A. Because you do have to factor in the access issue.

Page 172

Um, some providers may think that these -- that the Medicaid patients are more difficult, more time-consuming, more expensive patients to deal with. And you don't want to let that get in the way of still delivering quality care and access to care.
Q. Would it be fair to say, then, that you think that Medicaid programs ought to pay more than what other third-party payers pay?
MR. DRAYCOTT: Objection.
A. I think they need to do, within budgetary limits, all they can to assure access to the best providers in the state.
For example, if you look at orthopedic surgeons, or orthopedists, regardless of, of what an MCO and TennCare may be willing to pay those providers, they just, at one point in time just said, We don't do TennCare. So you got a heck of a problem there. Reimbursement level may have been more than any other third party, they just wouldn't participate. So you got to, you got to be careful about that.

Page 173

BY MR. TORBORG:
Q. Did your department or the state generally ever prepare studies or commission studies to compare provider acquisition costs to AWP?
A. No.
Q. Whether it be --
A. I don't think so.
Q. Do you recall the organization called Myers and Stauffer? Do any work with them?
A. I might have. I don't know.
Q. Did you -- did Tennessee Medicaid either itself or have someone else do any studies on what it cost to dispense prescription drugs in Tennessee?
A. Um, during, during my tenure, no. But I was aware -- I even had at least two that were done prior to my employment with the state. My predecessor had left, you know, in his files, and I had reviewed them, done by UT College of Pharmacy in Memphis.
Q. I wanted to ask you another question

Page 214

just very, very recently in the news as well? First DataBank's role in determining AWP in a settlement. McKesson chose not to settle and First Databank --

MR. DRAYCOTT: You are correct. There, there, there is a, I believe, a class certification occurred with respect to First DataBank.

THE WITNESS: McKesson is holding out.

MR. DRAYCOTT: There is also a settlement with respect to First DataBank.

THE WITNESS: Okay. That, that's the end of this, isn't it? This is 2000?

MR. DRAYCOTT: I'm going to let Mr. Torborg deal with your questions.

MR. TORBORG: Let me --

THE WITNESS: Okay. My, my -- the reason for saying that is, I'm more familiar with what's recently going on, and I think it's all related, okay?

BY MR. TORBORG:

Q. Well, let me bear, you know, bear down

Page 215

the document a little bit --

A. Okay.

Q. -- maybe I can refresh your recollection --

A. All right.

Q. -- about what this specific issue was in play here.

The letter refers to, in the second paragraph, a proposal that was discussed at the state pharmacy director's July 1999 national conference.

A. Right.

Q. Apparently there was a presentation made by United States Attorney Reed Stevens, HHSOF OIG associate counsel, Mary Ruden, and the Maryland MFCU director -- and MFCO is M-F-C-O -- C-U, Director Carolyn McElroy.

Do you recall at all, Mr. Sullivan, that meeting?

A. I probably was there.

Q. Do the names Reed Stevens, Mary Ruden and Carolyn McElroy ring a bell?

Page 216

A. Yes.

Q. You have attended meetings where they have been in attendance?

A. I'm sure I have.

Q. Have you had any conversations with Mr. Stevens at any point in time?

A. No. No.

Q. How about Ms. Ruden?

A. No.

Q. How about Carolyn McElroy?

A. No.

Excuse me.

Q. Look at the next paragraph. It states, Stated briefly, under impending change to current procedures, FDB will base the average wholesale price as it reports on market prices rather than the prices identified by manufacturers. Additionally, FTB will no longer report a price for a product unless its manufacturer has certified the completeness and accuracy of pricing information submitted.

Does this refresh your recollection at

Page 217

all about what -- this specific proposal?

A. Yes, sir.

Q. And as refreshed, do you -- can you tell me anything more about your recollection of this initiative?

A. Well, I just -- I'm just not sure whatever happened between then and today that is complying with that statement, whether it was or wasn't.

I think, you know, everybody might be missing the boat if, if they want to consider AWP to be an accurate assessment of what people pay for drugs.

Q. And --

A. This isn't going to fix it.

Q. And if you look further down the paragraph, the carryover paragraph on page 110, the second page of the exhibit, the sentence is that starts with More importantly. Do you see that?

A. Yes.

Q. It says, More importantly, in view of

Page 218

the Medicaid program's legal obligation to reimburse true provider acquisition costs, such an effort by the states to ensure payment is based on actual prices, it is mandatory. Do you see that?
A. Yeah, I see it.
Q. Do you recall a discussion at any meeting that state Medicaid programs have a legal obligation?
A. No. No.
Q. Was that consistent with your understanding of what was required by the state, Tennessee?
A. No.
Q. And what was your understanding of what was required?
A. Well, I mean why -- if there was a legal obligation to only reimburse true provider acquisition costs, then why do we go through the trouble of submitting state plans? You tell me what reimbursement is going to be.
Q. What do you mean by that?

Page 219

A. Well, why would -- if the federal government is saying you are legally obliged to pay no more than cost, then you tell me what cost is. Why do I bother submitting a state plan amendment that says I'm going to apply the lesser of this, or AWP minus that, or this or that or the other, that you approve if I'm legally obliged to paying cost. Obviously -- I mean you don't know what cost is. You can't -- or else you would dictate it.
Does that make sense?
Q. A little bit.
A. That's -- it's impossible to enforce, and I don't ever remember anybody ever telling me, Leo, you got a legal obligation to only pay true provider's cost. You do that and you won't have a program.
Only people that could do that is a 340B federally qualified health plan.
Q. If we go down to Paragraph 4 of this letter, or I'm sorry, toward the bottom of the page where there is an indent 4. Do you see

Page 220

that?
A. Um-hum.
Q. It states, If providers concede that reimbursement exceed acquisition costs but maintain that the surplus is necessary to cover ancillary costs of the drugs' administration, e.g., nursing or incidental supply expenses, their argument runs expressly counter to law. Under Medicaid program requirements reimbursement is dependent on the acquisition costs of the drugs, not the overhead costs involved in dispensing them.
Do you see that?
A. Yes.
Q. Okay. Do you agree with that statement?
A. No.
Q. Why not?
A. Well, I mean, in practicality, that's not the way it's done, and, and I never, I never was advised by my bosses or people from the regional office or people from central office of

Page 221

HFCA or CMS that that's the way things had to be done.
Q. And do you believe that reimbursement was limited to the actual acquisition costs of the drugs, that you would have an effective program that provided access to care to beneficiaries?
A. It would severely compromise access to care, in my opinion.
Q. And would that be true across all fifty states, in your opinion?
A. There may be some rural versus urban mix that, that might skew that, but I would think so.
Q. The next, next page, the carryover paragraph, first sentence, states, No entity charged with implementation or enforcement of Medicaid program rules can responsibly countenance a reimbursement system that violates the statutory obligation to reimburse provider acquisition costs.
Did you -- do you agree with that, Mr.